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## **80.000 Program Oversight**

This chapter includes information about the processes in place to ensure quality and consistency in the CRS program. It addresses CRS Regional Contractors' financial reporting requirements, program reporting requirements, quality and utilization management requirements, and CRSA program evaluation activities.

### **80.100 Financial Reporting Requirements**

1. CRS Regional Contractors will have a system in place to produce complete, timely, reliable, and accurate financial records in accordance with contract requirements for financial reporting. Contractor shall design and implement their financial operations system to ensure compliance with Generally Accepted Accounting Principles. Contractor shall also file with CRSA an annual (more frequently if required by CRSA) CMS-approved disclosure statement and related party transactions statement. CRSA shall evaluate all such statements to ensure that they conform to CMS requirements and, through its periodic audit and review procedures, shall ensure that the statements are complete and accurate. CRSA shall take immediate corrective action upon discovery of any failure to meet contract requirements.
2. CRS Regional Contractors receiving state funds shall comply with the certified financial and compliance audit provisions of the Office of Management and Budget (OMB) Circular A-128 or A-133, whichever is applicable, and the certified financial and compliance audit provisions of A.R.S. §35-181.03.
3. CRS Regional Contractors are required to provide CRSA with financial and cost information, in the manner specified by CRSA. Types of financial reports include:
  - A. Cost reports, in the schedules, formats, and timing specified by CRSA. The cost report must include inpatient, outpatient, and clinic data;
  - B. Audit report of CRS Regional Contractors' annual cost reports or financial statements, performed by an independent Certified Public Accountant (CPA);
  - C. Third party and family liability and collection reports, submitted in the format specified by CRSA; and
  - D. Other financial, regulatory, or program monitoring reports, as requested by CRSA for program analysis and oversight.

## **80.200 Program Reporting Requirements**

1. CRS Regional Contractors submit a variety of program reports and other data to CRSA to fulfill CRSA compliance responsibilities to funding agencies, and to assist CRSA in monitoring and oversight of the CRS program.
2. CRS Regional Contractors shall submit these reports and information in the format and specifications provided by CRSA.
3. CRS Regional Contractors shall furnish information and records relating to contract performance to CRSA upon request.

## **80.300 Delegated Quality Management/Performance Improvement Activities**

### **80.301 Policies and Procedures and Requirements for Delegated Activities**

1. The CRSA must oversee and be accountable for the QM/PI program; however, the CRS Regional Contractors must oversee and be accountable for any activities that are delegated to outside entities.
2. CRS Regional Contractors shall have policies and procedures that emphasize quality in all aspects of providing services to the CRS population. This requirement includes processes within the clinic setting as well as processes for monitoring other provider services outside of the clinic setting.
3. Delegation of any activities to another entity does not alleviate the Regional Contractor's responsibility for ensuring quality. Documentation must be kept on file, and available to CRSA upon request, that shows the following requirements have been met for the delegated functions:
  - A. A written agreement specifying the delegated activities and reporting responsibilities of the entity that provides for revocation of the delegation or other remedies for inadequate performance;
  - B. An evaluation by the Regional Contractor of the entity's ability to perform the activities prior to delegation;
  - C. Ongoing monitoring of the performance and quality of services provided and a formal review at least annually; and
  - D. Written evaluations and CAPs, as necessary.

### **80.302 Quality of Care Issues**

1. The Regional Contractor is responsible for investigating all quality of care allegations involving its own clinic activities as well as other services provided directly or through provider sub-contracts, regardless of the source

of the allegation. Quality of care issues identified through the grievance or appeal processes are subject to the requirements below in 5., 6., and 7.

2. Substantiated allegations must be resolved on both individual case and system levels. Cases shall not be closed until the actions needed for resolution are completed and assessed and until any system breakdown or deficiency that allowed the lapse in quality care to occur is successfully addressed.
3. The Regional Contractor shall maintain Quality of Care files on each case that shall contain detailed documentation of the research, actions and outcomes. The files shall be available to CRSA on request.
4. In addition to the requirements to notify CRSA when quality of care issues are identified through grievances and appeals, CRSA also shall be notified immediately of all quality of care issues with an initial severity level of 2 or above, as defined at the end of this chapter, when the Regional Contractor identifies an issue through its own internal processes or through audits and reviews by outside agencies or consultants.
5. The Regional Contractor shall have written policies and procedures for reviewing, evaluating, and resolving quality of care issues, regardless of who within the organization receives the grievances, that include:
  - A. Making a prompt determination of whether a grievance is a non-quality of care concern or a quality of care concern and assigning a severity level (Severity levels are defined at the back of this chapter. Zero equals non-quality of care and one and above equal quality of care issues.);
  - B. Identifying how the Regional Medical Director is informed of quality of care issues, is involved in the assignment of severity levels, and oversees interventions and final resolutions;
  - C. Immediately reporting initial severity level 2, 3, 4 to CRSA's Division of Quality Management;
  - D. Determining Quality of Care Categories (see table at the back of this chapter);
    - 1) main category; and
    - 2) subcategory;
  - E. Immediately reporting to CRSA closing severity level when higher than initial severity level;
  - F. Acknowledging receipt of the concern and explaining to the member or provider the process to be followed in resolving his or her concern through written correspondence. A Quality of Care Acknowledgement letter template (Attachment 1) is attached at the

- end of this chapter for use under the Regional Contractors own letterhead and with the name, title, credentials, and telephone number of the person sending the letter.
- G. Documenting all processes (include detailed steps used during the investigation and resolution stages) implemented to ensure complete resolution of each grievance determined to be a quality of care issue on both an individual and system level, including but not limited to interventions, including the provision of immediate medical needs as approved by the CRS Regional Medical Director.
  - H. Follow-up with the member that includes, but is not limited to:
    - 1) Assistance as needed to ensure that the immediate health care needs of the member are met; and
    - 2) A Quality of Care Resolution Letter (Attachment 2 at the end of this chapter) on the Regional Contractor's letterhead is sent. The letter shall provide sufficient details to ensure all covered, medically necessary health care needs are met; contact name/title and telephone number to call for assistance or to express any unresolved concerns; the name, title and credentials of the person signing the letter; and if applicable, the Member's AHCCCS ID number.
  - I. Documenting closure of the review.
6. Additional actions by the Regional Contractors may be necessary, based on individual case circumstances, before a case is closed. These actions may include:
- A. Referring/reporting the issue to appropriate regulatory agencies such as Child or Adult Protective Services, AHCCCS, and/or CRSA for further research/review or action;
  - B. Notifying the appropriate regulatory/licensing board or agency and CRSA when a health care professional's, organizational provider's or other provider's affiliation with their network is suspended or terminated because of quality of care issues; and
  - C. Referral to the CRSA Peer Review Committee.
7. The Regional Contractor is responsible for tracking Quality of Care issues. Procedures for tracking and trending shall include:
- A. Contractors must ensure that member health records, as well as the records described in Chapter 60, Section 202, are available and accessible to authorized staff or their organization and to appropriate State and Federal authorities, or their delegates, involved in assessing quality of care issues.
  - B. The CRS Regional Contractor shall log and track all quality of care issues;
  - C. The quality of care issues tracking log must be completed using

CRSA specified forms and/or databases. This includes:

- 1) interventions implemented to resolve and prevent similar incidences; and
  - 2) resolutions status of "substantiated", non-substantiated, and "unable to substantiate" quality of care issues.
- D. The logs and/or databases must be submitted to CRSA by the 15<sup>th</sup> of the month for the preceding month.

### **80.303 Credentialing and Re-credentialing Processes**

This policy covers credentialing, temporary/provisional credentialing and re-credentialing policies for both individual and organizational providers.

Accreditation of the Contractor, specific to its line of business serving AHCCCS and CRS State Only members, by the National Committee for Quality Assurance (NCQA) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will demonstrate that credentialing and re-credentialing requirements have been met.

If the Contractor is not accredited as described above, the standards outlined in this Chapter must be demonstrated through the Contractor policies and procedures. Compliance will be assessed based on the Contractor policies and standards in effect at the time of the credentialing/re-credentialing decision.

#### **Credentialing Individual Providers**

The Regional Contractor must have a system supported by written policies and procedures or bylaws for credentialing and re-credentialing providers included in their contracted provider network that meet CRSA and AHCCCS requirements.

1. Credentialing and re-credentialing must be conducted and documented for at least the following contracted health care professionals:
  - A. Physicians (MDs, DOs and DPMs);
  - B. Nurse practitioners, physician assistants or certified nurse midwives providing primary care services, including prenatal and delivery services;
  - C. Dentists;
  - D. Psychologists; and
  - E. Other certified behavioral health professionals who contract directly with the Contractor.
2. The Regional Contractor must ensure:
  - A. The credentialing and re-credentialing processes do not discriminate against:
    - 1) A health care professional, solely on the basis of license or certification, or
    - 2) A health care professional who serves high-risk populations

- or who specializes in the treatment of costly conditions.
- B. Compliance with Federal requirements that prohibit employment or contracts with providers excluded from participation under either Medicare or Medicaid.
3. If the Regional Contractor delegates to another entity any of the responsibilities of credentialing/re-credentialing or selection of providers that are required by this chapter, it must retain the right to approve, suspend, or terminate any provider selected by that entity and must meet the requirements for delegation in 80.301 above. The CRS Regional Contractor remains responsible for delegated credentialing or re-credentialing decisions and shall maintain a credentialing committee in which the Regional Medical Director has final authority for CRS credentialing decisions. CRSA will maintain oversight responsibilities over the Regional Medical Director's CRS credentialing decisions.
  4. Written policies must reflect the scope, criteria, timeliness and process for credentialing and re-credentialing providers. The policies and procedures must be reviewed and approved by the Regional Contractor's executive management, and:
    - A. Reflect the direct responsibility of the Medical Director or other designated physician for the oversight of the process and delineate the role of the credentialing committee;
    - B. Indicate the utilization of participating providers in making credentialing decisions; and
    - C. Describe the methodology to be used by Contractor staff and the Contractor Medical Director to provide documentation that each credentialing or re-credentialing file was completed and reviewed, as per (1) above, prior to presentation to the credentialing committee for evaluation.
  5. Regional Contractors must maintain an individual credentialing/re-credentialing file for each credentialed provider. Each file must include:
    - A. The initial credentialing and all subsequent re-credentialing applications;
    - B. Information gained through credentialing and re-credentialing queries; and
    - C. Any other pertinent information used in determining whether or not the provider met the Contractor's credentialing and re-credentialing standards.

### **Initial Credentialing**

At a minimum, policies and procedures for the initial credentialing of physicians and other licensed health care providers must include:

1. A written application to be completed, signed and dated by the provider that attests to the following elements:

- A. Reasons for any inability to perform the essential functions of the position, with or without accommodation;
  - B. Lack of present illegal drug use;
  - C. History of loss of license and/or felony convictions;
  - D. History of loss or limitation of privileges or disciplinary action;
  - E. Current malpractice insurance coverage; and
  - F. Attestation by the applicant of the correctness and completeness of the application.
2. Minimum five year work history
3. Drug Enforcement Administration (DEA) or Chemical Database Service (CDS) certification
4. Verification from primary sources of:
  - A. Licensure or certification;
  - B. Board certification, if applicable, or highest level of credentials attained;
  - C. Documentation of graduation from an accredited school and completion of any required internships/residency programs, or other postgraduate training, if the Contractor lists physician schooling information in member materials or on their web site; and/or
  - D. National Provider Databank (NPDB) query or, in lieu of the NPDB query, all of the following must be verified:
    - 1) Minimum five year history of professional liability claims resulting in a judgment or settlement, and
    - 2) Disciplinary status with regulatory board or agency, and
    - 3) Medicare/Medicaid sanctions.

### **Temporary/Provisional Credentialing**

Contractors must have policies and procedures to address granting of temporary or provisional credentials when it is in the best interest of members that providers be available to provide care prior to completion of the entire credentialing process.

Temporary, or provisional, credentialing is intended to increase the available network of providers in medically underserved areas, whether rural or urban. The Contractor must follow the "Initial Credentialing" guidelines 1 through 5 when granting temporary or provisional credentialing. The Contractor shall have 14 days from receipt of a complete application, accompanied by the minimum documents identified above, within which to render a decision regarding temporary or provisional credentialing.

The Contractor must follow the "Initial Credentialing" guidelines 1 through 4 above to complete the credentialing process following the granting of temporary or provisional credentials.

For consideration of temporary or provisional credentialing, at a minimum, a provider must complete a signed application that must include the following items:

1. Reasons for any inability to perform the essential functions of the position, with or without accommodation;
2. Lack of present illegal drug use;
3. History of loss of license and/or felony convictions;
4. History of loss or limitation of privileges or disciplinary action;
5. Current malpractice insurance coverage; and
6. Attestation by the applicant of the correctness and completeness of the application.

In addition, the applicant must furnish the following information:

1. Work history for past five years and
2. Current DEA or CDS certificate.

The Contractor must conduct primary verification of the following:

1. Licensure or certification;
2. Board certification, if applicable, or the highest level of credential attained; and
3. National Provider Data Bank (NPDB) query, or, in lieu of the NPDB query, all of the following:
  - A. Minimum five year history of professional liability claims resulting in a judgment or settlement; and
  - B. Disciplinary status with regulatory board or agency; and
  - C. Medicare/Medicaid sanctions.

The Contractor Medical Director must review the information obtained and determine whether to grant provisional credentials. Following approval of provisional credentials, the process of verification and committee review, as outlined in this Section, should be completed.

### **Re-credentialing Individual Providers**

At a minimum, the re-credentialing policies for physicians and other licensed health care providers must identify procedures that address the re-credentialing process and include requirements for:

1. Re-credentialing at least every three years;
2. An update of information obtained during the initial credentialing for sections (1) (except 1c), (3) and (4) (4 b) only requires update if provider is board certified); and
3. A process for ongoing monitoring, and intervention if appropriate, of provider sanctions, complaints and quality issues pertaining to the provider, which must include, at a minimum, review of:
  - A. Medicare/Medicaid sanctions;
  - B. State sanctions or limitations on licensure;
  - C. Member concerns which include grievances (complaints) and appeals

- information; and  
D. Contractor Quality issues.

### **Credentialing Organizational Providers**

For organizational providers included in its network (including hospitals, home health agencies, and free-standing surgi-centers):

1. Each Regional Contractor must validate, and re-validate at least every three years, that the organizational provider:
  - A. Is licensed to operate in the State, and is in compliance with any other applicable State or Federal requirements, and
  - B. Is reviewed and approved by an appropriate accrediting body or, if not accredited, Centers for Medicare and Medicaid Services (CMS) certification or State licensure review may substitute for accreditation. In this case, the Contractor must verify a review was conducted and compliance was achieved by obtaining a copy of the report.

### **CRSA Notification Requirement**

The Regional Contractor must report to the CRSA Medical Director, who shall bring before the CRSA Peer Review Committee, upon discovery, any known serious issue and/or quality deficiency that could affect quality of care provided to CRS members.

## **80.400 Medical Management (MM)/Utilization Management (UM) Activities**

### **80.401 Prior authorization**

1. CRS Regional Contractors shall have a system for prior authorization including policies and procedure, coverage criteria, and processes for approval/denial of services.
2. CRS Regional Contractors shall have prior authorization staff that includes an Arizona-licensed nurse/nurse practitioner or physician with appropriate training to apply CRS medical criteria or make medical decisions. In addition, Contractors shall have a system for maintaining files/documentation in a secured location.
3. CRS Regional Contractors shall use a standardized criterion (InterQual) to make prior authorization decisions for medical necessity.
4. The CRS Regional Contractors' prior authorization staff and CRS Regional Medical Director must attend Inter-rater Reliability Testing at least annually and as requested by CRSA. The CRS Regional Contractors shall have a process for additional education, training, and

- monitoring of staff. New employees must attend the Inter-rater Reliability Testing within six months of hire.
5. The Regional Contractors shall provide prior authorization for the following services:
    - A. All non-emergent inpatient surgeries and medical admissions;
    - B. Purchase of durable medical equipment and customized adaptive aids (i.e., any orthotic, prosthetic, hearing aids, eye glasses, chest vests, or medical equipment, including custom modified wheelchairs);
    - C. Outpatient diagnostic tests (including MRIs) and laboratory services outside the CRS Regional Contractor's existing sub-contractors;
    - D. Outpatient Positron Emission Tomography scans;
    - E. Non-emergent transportation services between CRS contracted hospitals/facilities;
    - F. All visits to be scheduled in a physician or dentist office;
    - G. Outpatient ambulatory surgery services;
    - H. Implantable bone conduction devices and tactile hearing aids; and
    - I. Non-formulary pharmacy requests.
  6. Written policy and procedure for prior authorization shall include the following elements:
    - A. CRS Regional Contractors shall have a process to authorize services in a sufficient amount, duration, or scope and pay special attention to Balance Budget Act (BBA) required timelines for the standard and expedited review process: 14 calendar days for standard requests versus 3 working days for expedited requests; with an extension option of an additional 14 calendar days for both types of requests. Timelines shall be met even if the member has other third party liability insurance.
    - B. When a CRS Regional Contractor or provider determines/indicates that the standard response time could seriously jeopardize the member's life, health, or ability to maintain/regain maximum function, an expedited authorization decision is to be made within three working days following receipt of the request for service.
    - C. CRS Regional Contractors shall have a process for requesting an extension for up to 14 additional calendar days if either the member or provider requests the extension or the Regional Contractor justifies a need for additional information. The extension must be in the member's best interest.
    - D. Extensions initiated by the CRS Regional Contractor must be documented in writing to the member using the Notification of Extension of Service Authorization Timeframe (Attachment 6).
    - E. CRS Regional Contractors shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary service.

- F. On the day the timeframe expires, if a determination is not made then it is considered a denial.
- G. The CRS Regional Contractor may consult with the requesting provider when appropriate.
- 7. CRS places the responsibility for obtaining prior authorization with the providers. The CRS Regional Contractors are responsible for verifying that the reviewing site is the proper CRS Regional Contractor to accept payment responsibility for the requested service.
- 8. The provider/physician is not guaranteed reimbursement with an authorization number. Documentation shall support the claim/service rendered.
- 9. The provider/physician shall complete a CRS Provider Services Requisition (PSR) form and transmit it to the CRS Regional Contractor Site where the service is to be provided.
- 10. Required Elements on Provider Services Requisitions (PSR) forms- A PSR form shall include (at a minimum) the following required elements:
  - A. CRS member name and date of birth;
  - B. Requesting physician's/provider's name and specialty;
  - C. Requesting physician's license number;
  - D. Signature of the requesting physician/provider and date;
  - E. CRS diagnosis;
  - F. Proposed date of service;
  - G. Proposed service to be provided;
  - H. Narrative description or supporting documentation/reason of medical necessity for the proposed service;
  - I. Record date that PSR request is received by CRS Regional Contractor;
  - J. Type of authorization request (standard or expedited);
  - K. CRS eligibility checked;
  - L. Service covered by CRS;
  - M. Third Party Liability (TPL) insurance checked (if applicable);
  - N. Complete referral service category (inpatient, ambulatory, physician's office);
  - O. Name of surgeon and assistant surgeon (if applicable);
  - P. Place for signature of authorizing medical professional and date of prior authorization approval;
  - Q. Date authorization notice was sent to provider, physician, or facility;
  - R. Sent by staff person's name; and

- S. Met timelines:
  - 1) Standard (14 calendar days)
  - 2) Expedited (3 working days)
  - 3) Extension (additional 14 calendar days; final decision within 28 calendar days).
- 11. CRS Regional Contractor shall have a process for authorizing the Provider Service Requisitions that shall determine whether the requested services are medically necessary and appropriate. Decisions on CRS coverage and medical necessity shall be based on the criteria found in Chapters 30 and 40 of this manual.
- 12. CRS Regional Contractors shall investigate or verify other coverage(s) to which the individual may be entitled, including any requirements for pre-certification by other carriers or liable parties. However, the fact that the Contractor is the secondary payer does not negate the Contractor's obligation to render a determination regarding coverage within the timeframes identified in Section 80.401, number 6.
- 13. CRS Regional Contractors' prior authorization staff (RN, BSN, MD) shall sign and date the authorization for services and send notice of the authorization to the requesting provider when completed.
- 14. CRS Regional Contractors shall place appropriate limits on services based on a reasonable expectation that the amount of services authorized will achieve the expected outcome.
- 15. All CRS Regional Contractors' prior authorization, concurrent, and retrospective decisions are subject to retrospective review by CRSA.
- 16. CRS Regional Contractors shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary service.
- 17. CRS Regional Contractors shall have procedures for denial of services that include:
  - A. A clinical review by the CRS Regional Medical Director of decisions to deny authorization on the grounds of medical appropriateness, medical necessity, or CRS coverage.
  - B. The ability of the CRS Regional Medical Director to consult with another appropriately credentialed CRS physician(s) regarding the requested procedure when the requesting physician challenges the denial.

- C. Notification of the requesting provider of any decision to deny, limit, or discontinue authorization of services including appropriate steps for appealing the decision.
- D. Proper documentation regarding the reasons behind the adverse decision.
- E. Adverse decisions shall only be rendered by the CRS Regional Medical Director, who must sign all denials (see Section 80.402).

**80.402 Notice of Action, Notice of Service Authorization Extension, Notice to ALTCS/Acute Care Provider and Health Plan**

1. The definition of an "Action" is:
  - A. The denial or limited authorization of a requested service, including the type or level of service;
  - B. The reduction, suspension, or termination of a previously authorized service;
  - C. The denial, in whole or in part, of payment for a service;
  - D. The failure to provide a service in a timely manner, as set forth in contract;
  - E. The failure of a contractor to act within the time frames required for standard and expedited resolution of appeals and standard disposition of grievances; or
  - F. The denial of a rural CRS member's request to obtain services outside the CRS Regional Contractor's network when the CRS Regional Contractor is the only Contractor in the rural area.
2. The CRS Regional Contractor must send a Notice of Action (Attachment 5) when:
  - A. When a service requested by a provider is denied, reduced, or terminated.
  - B. A request for a service from a member who the CRS Regional Contractor has the sole authority to approve or deny. (These are covered services that do not require a physician or qualified health care provider's order.)
3. The CRS Regional Contractor is not required to issue a notice when:
  - A. The CRS Regional Contractor issues a denial, reduction or termination of a service requested by a member for a service that requires a provider order. In these circumstances, it is expected that the Contractor timely refer the member to a provider.
  - B. The Regional Contractor denies, reduces or terminates a member's request for a service which the provider has declined to order. A second opinion must be provided in accordance with the federal and state requirements.

4. Regardless of the category of authorization request, if a member requests further recourse when a denial or limited authorization of a requested service is given, a Notice of Action must be provided to the member.

### **Language and Format of the Notice of Action**

1. The CRS Regional Contractor shall ensure that the Notice of Action is in writing and meets the following language and format requirements:
  - A. The CRS Regional Contractors must use the approved Notice of Action form included at the end of this chapter. The Notice of Action form language and format shall not be altered aside from adding CRS Regional Contractor Letterhead, member identification information, and member specific information in the areas identified with the word “INSERT.”
  - B. The Notice of Action shall be available in each non-English language spoken by a significant number or percentage of members or potential members in the contractor's geographic service area as established by contract. The Notice of Action shall explain that free oral interpretation services are available to explain the Notice of Action for all non-English languages.
  - C. The Notice of Action must clearly explain at a fourth grade level the service being denied, reduced, or terminated and the reason for the action.

### **Content of the Notice of Action**

1. The CRS Regional Contractor shall ensure that the Notice of Action explains the following:
  - A. The action the CRS Regional Contractor has taken or intends to take;
  - B. The reasons for the action including references to federal and state rules and regulations upon which the action is based;
  - C. The member's right to file an appeal with the CRS Regional Contractor;
  - D. The procedures for exercising the right to file an appeal;
  - E. The circumstances under which an expedited resolution is available and how to request it; and
  - F. The circumstances under which a member has a right to have services continue pending resolution of the appeal, how to request that services be continued, and the circumstances under which the member is liable for the costs of services.
2. The Notice of Action letter must be signed by the CRS Regional Contractor Medical Director.

## General Requirements

1. The CRS Regional Contractor responsible for the action is responsible for providing the Notice of Action.
2. Timeframes for the Provision of the Notice of Action:
  - A. When authorization for a requested service is denied, a Notice of Action shall be provided to the recipient as expeditiously as the health condition requires, but not later than:
    - 1) 14 calendar days for standard authorization denials; or
    - 2) Within 3 working days for expedited authorization decisions
    - 3) Authorization decisions may be extended for up to 14 days, as described in 80.401 above (Attachment 6).
  - B. When continued authorization for a requested covered service is terminated, reduced or suspended, a Notice of Action shall be provided to the recipient at least 10 days prior to the date of the intended action, or at least 5 days prior to the date of the intended action in the case of suspected fraud. The CRS Regional Contractor may shorten the period of advance notice to 2 days before the date of intended action for the termination of non-emergency inpatient services, as a result of the denial of a continued stay request. A Notice of Action may be delivered on the date of action under the following circumstances:
    - 1) Death of recipient;
    - 2) Written statement by recipient that services are no longer wanted;
    - 3) Recipient is age 21-64 and in an IMD for over 30 days;
    - 4) Recipient is an inmate of a public institution not receiving federal financial participation;
    - 5) Whereabouts of recipient are unknown and post office returns mail indicating no forwarding address; or
    - 6) Acceptance into another State's Medicaid Program.
  - C. Delivery of the Notice of Action  
The Notice of Action must be:
    - 1) Sent to the Member or their legal or authorized representative, and copied to the ALTCS/Acute Care Contractor and/or the requesting provider, as appropriate.
    - 2) A copy of the Notice of Action must be retained in the clinic record.

## Notices to an ALTCS/Acute Care Contractor

1. Requests received by an ALTCS/Acute Care Contractor for a service to a CRS recipient:
  - A. The ALTCS/Acute Care Contractor shall conduct a review of the

request for medical necessity.

- B. If the ALTCS/Acute Care Contractor believes the service is not medically necessary, the ALTCS/Acute Care Contractor shall contact a CRS Regional Medical Director for a second opinion to determine whether CRS concurs with the ALTCS/Acute Care Contractor's determination. CRS shall determine whether the requested service is medically necessary and shall respond to the ALTCS/Acute Care Contractor within 1 working day. The entire process shall occur with the standard authorization timeframe of 14 days.
- C. If the CRS Regional Medical Director concurs that the service is not medically necessary, the ALTCS/Acute Care Contractor shall deny the request and send a Notice of Action to the member.
- D. If the CRS Regional Medical Director determines that the service is medically necessary, CRS and the ALTCS/Acute Care Contractor shall follow the process in 1.F.1 & 2.
- E. If the ALTCS/Acute Care Contractor determines the service is medically necessary and believes that the service is a CRS covered benefit, the ALTCS/Acute Care Contractor shall:
  - 1) Notify CRS of the request; and
  - 2) Simultaneously inform the member that a 14-day extension is being taken (a decision must be rendered no later than 28 days from the date the request was initiated) to provide the decision to the member and provider.
- F. CRS shall review the request:
  - 1) If CRS approves the services:
    - a) It will notify the ALTCS/Acute Care Contractor.
    - b) The ALTCS/Acute Care Contractor shall notify the member in writing that the service will be provided by CRS and direct the member to CRS.
    - c) The ALTCS/Acute Care Contractor shall assist the member in contacting CRS.
  - 2) If CRS denies the services:
    - a) It will send **no** notice to the member.
    - b) It will notify the ALTCS/Acute Care Contractor in writing of its decision (Attachment 7).
    - c) The notification shall also inform the Medical Director of the ALTCS/Acute Care Contractor of the right to appeal the decision by filing a Request for Review in writing with the CRS Regional Medical Director no later than 10 business days after the decision.
    - d) The ALTCS/Acute Care Contractor will:
      - i) Process the request within the 28-day

- timeframe of the original request.
  - ii) Provide requested services as ordered, or provide limited authorization of the request. If limited authorization is provided, the Contractor shall issue a Notice of Action to the member.
- e) Upon receipt of the Request for Review by CRS:
  - i) The CRS Regional Medical Director shall issue a written decision to the ALTCS/Acute Care Contractor no later than ten (10) business days from the date of the receipt of the Request for Review (Attachment 8).
  - ii) The CRS decision shall advise the ALTCS/Acute Care Contractor Medical Director that the ALTCS/Acute Care Contractor may file a request for hearing with the AHCCCS Administration within thirty (30) days of receipt of the CRS decision in the event that the ALTCS/Acute Care Contractor disagrees with the CRS decision.
- f) If the AHCCCS Hearing Decision determines that the service should have been provided by CRS, CRSA shall be financially responsible for the costs incurred by the ALTCS/Acute Care Contractor in providing the service.
- g) The timing of the above steps shall be as follows:
  - i) Day 1 (day request is received) through Day 5 - ALTCS/Acute Care Contractor review, if not a CRSA covered benefit and approve or deny the request;
  - ii) Day 6 - Fax to CRS with medical documentation to support the request;
  - iii) Day 7 through Day 15 - CRS review;
  - iv) Day 16 - CRS to fax or call the ALTCS/Acute Care Contractor with the decision. If CRS denies the request, CRS proceeds as in III, (D)(4). If CRS authorizes the service, CRS and the ALTCS/Acute Care Contractor proceeds as in Section III, (D)(3); and,
  - v) Day 17 through Day 28 ó If CRS denies the request, ALTCS/Acute Care

Contractor authorizes the service. If the ALTCS/Acute Care Contractor provides limited authorization of the request, issues a Notice of Action. ALTCS/Acute Care Contractor may follow the Request for Review guidelines. [Refer to the process in V, E, 5, b, 3).]

- h) The ALTCS/Acute Care Contractor is responsible for rendering the decision no later than the total 28-day timeframe beginning when the date request is received. If CRS fails to issue an authorization decision within the above timeframe, the ALTCS/Acute Care Contractor shall authorize the request and provide the service. Then, the ALTCS/Acute Care Contractor may file a request for hearing with the AHCCCS Administration within 30 days from the date the authorization decision should have been issued by CRS.
- 2. Request received by an ALTCS/Acute Care Contractor for a member who is not enrolled with CRS.
  - A. If the Contractor reasonably believes that the member has a CRS condition and the service is related to that condition, the Contractor shall:
    - 1) For urgent requests:
      - i) Initiate a Medical Director to Medical Director communication for urgent requests.
      - ii) If the request meets medical necessity guidelines and is date sensitive, the ALTCS/Acute Care Contractor must review and follow medical guidelines to assure that medically necessary care is not delayed.
    - 2) For non-urgent requests:
      - i) The ALTCS/Acute Care Contractor shall refer the member to CRS.
      - ii) The ALTCS/Acute Care Contractor shall issue a Notice of Action to the member denying the service referencing that CRSA may be the responsible entity for the service and that the member must establish eligibility with CRSA.
      - iii) The ALTCS/Acute Care Contractor shall assist the member in contacting CRS as necessary. (Refer to the process as a Request for Review.)
      - iv) The ALTCS/Acute Care Contractor will monitor the CRSA application to ensure that the process is

- completed by the member's legal guardian.
    - v) The ALTCS/Acute Care Contractor will monitor the CRSA application outcomes in order to ensure ordered medically necessary care is provided.
    - vi) In the event that CRS determines that the member does not meet the medical eligibility requirement for participating in the CRS program, CRS shall inform the referring physician and the applicable ALTCS/Acute Care Contractor, in writing, of the denial and the reason for the denial within 5 working days of the denial.
  - 3. Request received by CRS for AHCCCS members who are CRS recipients
    - A. CRS shall determine if the request is a CRS covered benefit.
    - B. If CRS determines the request is not a CRS covered benefit:
      - 1) CRS will send no notice to the member, but shall notify the ALTCS/Acute Care Contractor in writing (Attachment 9).
      - 2) Simultaneously, CRS shall inform the member in writing that:
        - i) A 14-day extension is being taken (not to exceed 28 days) (Attachment 10);
        - ii) The service request is not a CRS covered benefit; and,
        - iii) That the request is being referred to the member's primary AHCCCS plan.
      - 3) CRS shall direct the member to the ALTCS/Acute Care Contractor.
      - 4) CRS shall assist the member in contacting the ALTCS/Acute Care Contractor.
    - C. ALTCS/Acute Care Contractor shall review the request and:
      - 1) Shall conduct a review of the request for medical necessity.
        - i) If the ALTCS/Acute Care Contractor determines that the service is not medically necessary, the Contractor shall deny the request and send a Notice of Action to the member and notify CRS of its decision.
        - ii) If the request is determined medically necessary and is not a CRS covered benefit, the Contractor shall authorize the service and notify CRS in writing of its decision.
        - iii) If the request is determined medically necessary and is presumed to be a CRS covered benefit, the ALTCS/Acute Care Contractor shall authorize the

service and may file a request for hearing with the AHCCCS Administration within thirty (30) days of receipt of the CRS decision.

- 2) The timing of the above steps shall be as follows:
  - i) Day 1 (day request is received) through Day 5 of CRS review;
  - ii) Day 6 of Fax to ALTCS/Acute Care Contractor with medical documentation to support request;
  - iii) Day 7 through Day 15 of ALTCS/Acute Care Contractor review for medical necessity; and,
  - iv) Day 18 through 28 of ALTCS/Acute Care Contractor authorizes the services or issues a Notice of Action to the member when a requested service is denied or a limited authorization is given.

#### **80.403 Concurrent Review**

1. CRS Regional Contractors shall have a system of utilization review for a member's hospital admission and hospital stay. The CRS Regional Contractor Medical Director oversees this process.
2. CRS Regional Contractors shall have procedures for review of medical necessity prior to a planned institutional admission (prior authorization) and for determination of the medical necessity for ongoing institutional care (concurrent review) using standard criteria (InterQual's Level of Care Criteria).
3. CRS Regional Contractors shall have adequate, qualified, and professional medical staff (i.e., physician, physician assistant, nurse practitioner, and/or RN/BSN) to conduct reviews.
4. The CRS Regional Contractors shall have policies and procedures that contain the following elements for the concurrent review process:
  - A. CRS Regional Contractors shall have a process to ensure that the medical necessity review must include what relevant clinical information is to be obtained when making hospital length of stay decisions such as diagnosis, required services, diagnostic test results, and symptoms.
  - B. CRS Regional Contractors shall ensure consistent application of review criteria and compatible decisions that include Inter-rater Reliability criterion and monitoring of all staff involved in the concurrent review process, including the CRS Regional Medical Director.

- C. CRS Regional Contractors shall ensure that all previously (prior) authorized stays will have a specific date by which the need for continued stay would be reviewed.
  - D. Reviews of an admission not prior authorized will be conducted within 1 business day after notification. The extension of a continued stay shall be assigned a new review date each time a concurrent review occurs.
  - E. Decisions on coverage and medical necessity must be clearly documented.
  - F. CRS Regional Contractors shall ensure that they have a process for review by another qualified physician in the event an ordering physician challenges a length of stay or level of care determination or decision of medical necessity.
  - G. CRS Regional Contractors concurrent review staff shall have a process in place to communicate with the CRS Regional Medical Director when a CRS member is found ineligible for a particular service or set of services.
  - H. CRS Regional Contractor's utilization review staff shall coordinate with the hospital/facility's Utilization Review Department and Business Office regarding any change in authorization status.
  - I. All denials for continued services shall be signed by the CRS Regional Contractor Medical Director.
  - J. Written notification of a denial of hospital days or services for a CRS member shall be sent to the CRS attending physician and all representative parties, including the insurance carrier, parent, or guardian, within 24 hours prior to date of discontinued coverage.
5. All CRS Regional Contractor prior authorization, concurrent, and retrospective decisions are subject to retrospective review by CRSA.

#### **80.404 Decertification of a Hospital Stay**

- 1. CRS Regional Contractors shall have a system in place to manage CRS care and monitor the appropriateness of services. The CRS Regional Contractor Medical Director oversees this process.
- 2. All elective and urgent hospital/ambulatory admissions are reviewed by the CRS Regional Contractor's authorization department. If, during the course of hospitalization, the CRS member is determined by the concurrent review nurse to be potentially medically ineligible or is potentially ineligible for a particular service or set of services, the following will occur:
  - A. CRS Regional Contractor's utilization review staff will review the pertinent information/medical record with the CRS Regional Medical

- Director or designee;
- B. If the CRS Regional Contractor's Medical Director makes the denial, the authorization status will reflect decertification of continued hospital days or services;
  - C. CRS Regional Contractors Medical Director shall sign all denial, reduction, or modification of services;
  - D. CRS Regional Contractor's utilization review staff will coordinate with the contracting hospital's Utilization Review Department and Business Office regarding any change in authorization status; and
  - E. Written notification of a denial of hospital days or services for a CRS member (decertification) shall be sent to the CRS attending physician and all responsible parties, including the insurance carrier and parent or guardian, within 24 hours prior to the date of discontinued coverage; however, no notice of action shall be sent to AHCCCS members/families. Please refer to Section 80.402 for appeals process.
  - F. CRS Regional Contractors will not be financially responsible for hospitalization and/or the physician component of care after the date of the denial.

#### **80.405 Retrospective Review**

1. CRS Regional Contractors shall have a system for retrospective review including policies and procedures, coverage criteria, and processes for approval/denial of services.
2. CRS Regional Contractors shall have qualified staff that includes an Arizona licensed nurse/nurse practitioner or physician with appropriate training to apply CRS medical criteria or make medical decisions. In addition, Contractors shall have a system for maintaining files/documentation in a secured location.
3. CRS Regional Contractors shall use a standardized criterion (InterQual) to make retrospective review decisions for medical necessity.
4. The CRS Regional Contractor's retrospective review staff and CRS Regional Medical Director must attend Inter-rater Reliability Testing at least annually and as requested by CRSA. The CRS Regional Contractor shall have a process for additional education, training, and monitoring of staff. New employees must attend the Inter-rater Reliability Testing within six months of hire.
5. CRS Regional Contractors must complete retrospective reviews for all emergency services. A Retrospective Review form containing all the

essential elements to determine medical necessity for the emergency service(s) shall be utilized.

6. Retrospective Review Required Elements:
  - A. Review was conducted by a qualified and professional medical staff;
  - B. A standard form was used for the review;
  - C. Dates are clearly specified to ensure timelines were met (e.g., date service was provided, date CRS was notified, and the date of the retrospective review);
  - D. Determination of necessity of emergency service setting;
  - E. CRS eligible diagnosis was relevant to emergency services;
  - F. Services met the member's needs; and
  - G. Decisions on coverage and medical necessity are clearly documented.
7. The timeframes for Retrospective Reviews shall not exceed 28 days from date of receipt of notification.
8. All CRS Regional Contractor prior authorization, concurrent, and retrospective decisions are subject to retrospective review by CRSA.

#### **80.406 Drug Utilization Patterns**

The purpose of Drug Utilization Review (DUR) is to assure the clinically appropriate, safe, and cost effective use of drug therapy to improve health status and quality of care. CRS Regional Contractors must develop policies and procedures that include prospective review processes for:

1. All drugs before dispensing. This process may be accomplished at the pharmacy using a computerized DUR system; and
2. All non-formulary drug requests.

#### **80.407 Case Management/Care Coordination**

1. Contractors must establish a process to ensure coordination of care for members that includes:
  - A. Coordination of CRS health care through a multi-specialty, interdisciplinary treatment plan; and
  - B. Collaboration with providers, communities, agencies, service systems, members, and families; and
  - C. Consultation reports sent to the referring physician and appropriate health plan within 30 days of the first visit to include:
    - 1) Plan of care;
    - 2) Diagnosis; and
    - 3) Name, address and phone number of the CRS provider.

- D. CRS shall provide service coordination, communication, and support services designed to manage the transition of care for a member who requires temporary care within an alternative delivery system, or who no longer meets CRS eligibility requirements.
2. Information regarding CRS services shall be shared in a timely manner with all other appropriate professionals, with the member's or family's consent, through discharge planning activities, interdisciplinary team meetings, and service coordination activities.
3. CRS shall also notify an AHCCCS member's health plan/program contractor of the member's discharge when appropriate for care coordination.

**80.408 Facility Transfers (For more detail, please refer to Chapter 40, Section 40.901, "Transfer of Care")**

1. CRS Regional Contractors may authorize facility transfers for CRS members only under the following conditions:
  - A. The transfer occurs between CRS contracted facilities;
  - B. The transfer is for the treatment of a CRS condition;
  - C. The transfer or transport is ordered and approved by a CRS Regional Contractor's provider; and
  - D. The transfer or transport is reviewed in advance and authorized by the CRS Regional Medical Director.
2. The transferring agency must complete applications for transfers in writing and shall include all diagnostic information regarding the CRS condition. The CRS Regional Contractor Medical Director or designee reviews the documentation to support the transfer, along with other consultation disclosures, and approves or denies the request for the transfer.
3. A transfer must be completed within forty-five (45) days. The CRS Regional Contractor's performance will be measured based on a minimum acceptable performance of 75% in the first year and 85% for the subsequent year, with a goal of 90%.
4. If a transfer is approved, and it is subsequently determined that the transferring agency failed to provide complete or accurate information about the member's condition, which resulted in a transfer of a member to treat an ineligible condition, CRS may transfer the member back to the originating facility at the expense of the original transferring agency.
5. When completing facility transfers, a member does not need to undergo the entire eligibility determination process again. No initial medical evaluation or eligibility/financial appointment is necessary as long as the member was still enrolled with the transferring site at the time of the transfer. An appointment shall be conducted to review the plan for treatment at the receiving site.

**80.409 Transition of Care**

CRS Regional Contractors shall have a system for transition of care to ensure compliance with continuity of care for all CRS members.

1. Pediatric to Adult Transition:

For CRS member's who are transitioning to adult services, the CRS Regional Contractor shall initiate a transition plan by age fourteen (14) which is ongoing until the member leaves the CRS program.

The transition plan shall:

- A. Establish a timeline for completing all services the member should receive through CRS prior to his or her twenty-first birthday;
- B. Advise the member's primary care provider of the discharge and ensure coordination of the services with the adult primary care provider;
- C. Ensure families, members, and their primary care providers are part of the development and implementation of the transition plan;
- D. Document the transition plan in the medical record;
- E. Coordinate the transition plan with the appropriate:
  - 1) AHCCCS health plan;
  - 2) ALTCS program contractors;
  - 3) IHS/638 and tribal entities upon discharge from a CRS clinic and/or discharge from the CRS program; and
  - 4) Private insurance.

2. Members aging out of the CRS system:

- A. CRS Regional Contractors shall have a system for transition of care to ensure compliance for continuity of care for members aging out of the CRS system;
- B. The CRS Regional Contractor shall notify the member's primary health care provider/AHCCCS Contractor in writing sixty (60) days prior to the member's 21<sup>st</sup> birthday to ensure continuity of care. CRS is not financially responsible for an AHCCCS member on or after his/her 21<sup>st</sup> birthday.
- C. CRS Regional Contractors shall ensure that an ETI (Enrollment Transition Information) Form (AHCCCS Exhibit 520-2, available at <http://www.ahcccs.state.az.us/Regulations/OSPpolicy/chap500/Cchap500.pdf>), is completed for all CRS enrolled members sixty (60) days prior to their 21<sup>st</sup> birthday and placed in the medical record;
- D. CRS Regional Contractors shall submit a copy of all ETI forms to the CRSA MM/UM Program on a monthly basis;
- E. The CRS Regional Contractors compliance for continuity of care for member(s) aging out of the CRS system shall be evaluated monthly by a CRSA UM Specialist.

**80.410 Referral Management**

The CRS Regional Contractor will have a policy and procedure for referral of members for specialized care. Examples of referrals include: out of state referrals, second opinions, referrals from one CRS clinic specialist to another, health plan referrals, referrals from primary care providers to CRS clinics, and intersite transfers.

**80.411 Adoption and Dissemination of Practice Guidelines**

Contractors must develop a process to ensure practice guidelines are disseminated by the Contractor to all affected providers and, upon request, to members and potential members.

**80.412 New Medical Technologies and New Uses of Existing Technologies**

CRS Regional Contractors may initiate a request for CRS coverage for new medical technologies and submit the proposal to the CRSA Medical Director for review. The proposal must include medical necessity criteria, supporting documentation, and a cost analysis for the new medical technology.

CRS Regional Contractors shall participate in the review of new medical technologies and new uses of existing technologies through the CRSA/CRS Medical Directors Meeting.

CRSA shall review the requests and respond in a timely manner to the Regional Contractors on the decision for coverage by the CRS Program.

**80.413 Discharge Planning**

1. The CRS Regional Contractor shall have policies and procedures that address discharge planning that include:
  - A. Inpatient discharge planning;
  - B. Pediatric to adult transition planning; and
  - C. Discharge planning for members exiting the CRS program.
2. For CRS members receiving inpatient services, the CRS Regional Contractor shall:
  - A. Initiate discharge planning upon the member's hospital admission;
  - B. Include coordination with all agencies responsible for post-hospital care (e.g., CRS, DES/DDD, AHCCCS, ALTCS, DES/CMDP and DES Adoption Subsidy); and
  - C. Transfer and decertify CRS authorized admissions for the CRS members in accordance with the specific ADHS/CRS policy.
3. For CRS members exiting the CRS system and/or CRS members who are

transitioning to adult services, refer to Section 80.409.

4. For CRS members aging out of the CRS system, refer to Section 80.409.

#### **80.414 Specialty Referral Timeline**

1. The CRS Regional Contractor shall have a policy and procedure that ensures adequate access to care through scheduling of appointments to specialists within 45 days of the date of a referral request. For urgent requests the timeframe for an appointment is 72 hours.
2. The CRS Regional Contractor shall maintain and provide to CRSA a detailed list of their providers and their specialties and will submit monthly reports of requests for referrals to specialists. If AHCCCS health plans are required to render any CRS-covered service due to the CRS Regional Contractor's failure to meet medically necessary appointment standards, the CRS Regional Contractor shall be financially responsible for those services.
3. The Contractor shall be subject to sanction for failure to meet appointment standards.

#### **80.415 Telephonic Response Standards**

Regional Contractors shall have sufficient staff and policies and procedures to handle phone calls from members and applicants promptly and appropriately.

#### **80.500 Other Program Activities**

##### **80.501 New Member Orientation Packet**

1. CRS Regional Contractors must, on an annual basis, inform all members of their right to request at a minimum:
  - A. An updated CRS Member Handbook; and
  - B. An updated comprehensive directory of the CRS Regional Contractor's Clinic Providers.
2. CRSA shall provide the Regional Contractors with a current CRS Member Handbook.
3. The CRS Regional Contractors shall:
  - A. Develop, distribute and maintain a New Member Orientation Packet;
  - B. Have New Member Orientation Packets available to all new members at the time of their initial appointment; and
  - C. Submit the New Member Orientation Packets annually to CRSA for review and approval.
4. New Member Orientation Packets must:
  - A. Contain a current CRS Member Handbook;
  - B. Contain a comprehensive directory of the CRS Regional

Contractor's Clinic Providers, which includes:

- 1) Specialty clinic providers' names;
  - 2) Specialty clinic telephone numbers;
  - 3) Non-English languages spoken by the providers;
  - 4) If any revisions, the date of last revision;
  - 5) Any restrictions or an explanation of the member's freedom of choice among clinic providers;
  - 6) A reference to the contractor's website for a complete listing of all its network providers.
- C. Be printed in a type, style and size that can be easily read by recipients with varying degrees of visual impairment and meet the ADA regulations;
- D. Be written at a 4<sup>th</sup> grade reading level;
- E. Have a date of the last update of the materials included;
- F. Provide written notification that alternate formats are available and how to access them;
- G. Provide written notification that oral interpreter services are available free of charge upon request; and inform potential enrollees and members on how to access those services;
- H. Contain information on the following:
- 1) The Regional Contractor's CRS Parent Action Council;
  - 2) Family and parent organizations and other appropriate resources including community service agencies.

## **80.502 Provider Manual**

1. CRS Regional Contractors shall:
  - A. Develop and maintain a Provider Manual;
  - B. Have Provider Manuals available to all contracted providers;
  - C. Submit the Provider Manuals annually to ADHS/CRSA for review and approval.
2. Provider Manuals must:
  - A. Be organized and in a style that is easy to follow;
  - B. Contain current information;
  - C. Contain a signature of the CRS Regional Contractor Administrator indicating their review and approval of the manual;
  - D. Have a date of the last update;
  - E. At a minimum include:
    - 1) An introduction to the CRS Regional Contractor explaining its organization and administrative structure;
    - 2) The providers' responsibility and the CRS Regional Contractor's expectations of the providers to include their role in quality and utilization management initiatives;
    - 3) An overview of the CRS Regional Contractor's Provider

- Service department and function;
- 4) A listing and description of covered and non-covered services, requirements and limitations;
- 5) Emergency Room utilization (appropriate and non-appropriate use of the emergency room);
- 6) Dental services;
- 7) Referrals to specialists and other providers to include, when applicable, coordination of services with AHCCCS Health Plans/ALTCS Plans and their providers;
- 8) A listing of enrollee rights and responsibilities as outlined by CRSA with a notation that the providers must provide care in accordance with these rights;
- 9) A statement that the provider is not restricted from advising or advocating on behalf of an enrollee who is his/her patient for the following:
  - a) The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
  - b) Any information the enrollee needs in order to decide among all relevant treatment options;
  - c) The risks, benefits, and consequences of treatment or non-treatment; and
  - d) The enrollee's right to participate in decisions regarding his/her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- 10) A statement notifying the providers that with the enrollee's written consent, they have the right to act on behalf of the enrollee and file an appeal;
- 11) Copies of any CRS Practice Guidelines;
- 12) Copy of the CRSA Peer Review Policy;
- 13) Claims disputes and hearing rights;
- 14) Billing and encounter submission information;
- 15) An indication of the form, UB92, HCFA 1500, or Form C that is to be issued for services;
- 16) An indication of the fields required for a claim to be considered acceptable by the CRS Regional Contractor;
- 17) Completed samples of UB92, HCFA 1500, or Form C;
- 18) CRS Regional Contractor's written policies and procedures which affect the provider(s) and/or the provider network including:
  - a) Claims re-submission policy and procedure;
  - b) An explanation of remittance advice;
  - b) Prior authorization requirements;

- c) Claims medical review;
  - d) Concurrent review;
  - e) Fraud and Abuse;
  - f) How to access formularies; and
  - g) ADHS/CRSA appointment standards.
- 19) Information on how to obtain educational materials and to access interpretation and translation services for members who have Limited English Proficiency (LEP) or prefer to speak a language other than English, or who use Braille or sign language;
  - 20) Americans with Disabilities Act (ADA) requirements when providing services outside the CRS Regional Clinic setting;
  - 21) A statement that providers are required to provide members with information regarding their health care including available treatment options and alternatives in a manner appropriate to the member's condition and ability to understand;
  - 22) A statement that providers must allow members to participate in decisions regarding their health care, including the right to refuse treatment;
  - 23) A statement that providers are required to assist members with Limited-English Proficiency (LEP) at all points of contact including providing sufficient access to interpreters and ensuring the qualifications of bilingual staff;
  - 24) A statement that providers and staff are to treat all members with respect, dignity, and consideration for privacy;
  - 25) A statement that in the process of coordinating care, each member's privacy is protected in accordance with privacy requirements;
  - 26) A statement that medical records and any other health and enrollment information that identifies a particular member must be confidential, according to requirements of HIPAA;
  - 27) Providers need to ensure that members are free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
  - 28) CRS member's have the right to obtain a second opinion free of charge from an appropriately qualified health care professional and providers may need to assist the member with a referral to the Contractor;
  - 29) The member must be free to exercise his/her rights, without adversely affecting the way the providers and their staff treat the member;
  - 30) Providers are to provide information on advance directives to adults (18 years and older) and to acknowledge the

- member's rights under the law of the State to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;
- 31) Providers must document in the medical record whether or not the individual has executed an advance directive and must not contain the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;
  - 32) Providers have the right to file a grievance (complaint, expression of dissatisfaction) with the Contractor. A provider, acting on behalf of the member with the member's written consent, may file an appeal. A provider may file a grievance or request a State Administrative Hearing on behalf of the member;
  - 33) Providers have the right to file an appeal of a medical service denial, suspension, or reduction on behalf of a member with the member's written consent;
  - 34) Providers have been given specific information about timelines for filing an appeal;
  - 35) Upon request of a member, the provider must provide them with a copy of the member's medical records and respond to a request that may be amended or corrected; and
  - 36) Provide cultural competency information, notification about Title VI of the Civil Rights Act of 1964, Culturally Linguistically Appropriate Services (CLAS) standards and Limited English Proficiency (LEP). Providers should also be informed of how to access interpretation and translation services to assist recipients who are LEP and speak a language other than English or who use sign language.

## **80.503 Policy and Procedure Manuals**

- 1. Each CRS Regional Contractor shall develop and maintain a Policy and Procedure manual that includes the processes for carrying out the requirements of the RCPDM. Each policy must contain the following:
  - A. A clear title;
  - B. Contain a signature of the CRS Regional Contractor Administrator indicating their review and approval of the policy and/or procedure;
  - C. The original date of the policy;
  - D. The last date the policy or procedure was updated;
  - E. The last date the policy or procedure was reviewed;
  - F. Content that is complete and concise; and
  - G. A process for continuous review of personnel and subcontractor

- performance.
2. CRS Regional Contractors Policies and Procedures must be reviewed at least annually, and updated as needed to reflect changes in the RCPPM.
  3. CRS Regional Contractors must maintain updated copies of the AHCCCS Medical Policy Manual (AMPM) and the AHCCCS Contractor Operations Manual (ACOM).

#### **80.504 Contract Monitoring**

ADHS and any other appropriate agent of the State or Federal Government, or any of their duly authorized representatives, shall have access during reasonable hours to the Regional Contractor's facilities and the right to examine the contractor's books, documents, and records involving transactions related to their contract with ADHS/CRS.

#### **80.600 Provider Network Development and Management**

CRS Regional Contractors must:

1. Maintain a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract.
2. Not discriminate with respect to participation in the CRS program, reimbursement, or indemnification against any provider based solely on the provider's type of licensure or certification.
3. Give the affected providers written notice of the reason for its decision, if a Regional Contractor declines to include individual or groups of providers in its network. CRS Regional Contractors may not include providers excluded from participation in Federal health care programs.
4. Have policies and procedures in place that pertain to all service specifications specifying how they will:
  - A. Communicate with the CRS network regarding contractual and/or program changes and requirements;
  - B. Notify affected members within 15 days of CRS acquiring knowledge that a provider is leaving the network [42 C.F.R. § 438.10(f)(5)];
  - C. Notify affected members of material program changes at least 30 days prior to the effective date of the change [42 C.F.R. § 438.10(f)(4)];
  - D. Monitor and ensure network compliance with policies and rules of AHCCCSA and CRSA;
  - E. Evaluate the quality of services delivered by the network;
  - F. Provide or arrange for medically necessary covered services should the CRS network become temporarily insufficient;

- G. Monitor network capacity to ensure that there are sufficient providers to handle the volume and needs of CRS recipients. This includes staff and other resources to handle the language needs involved in the provision of care to CRS recipients with Limited English Proficiency; and
  - H. Ensure service accessibility, including monitoring appointment standards, and appointment waiting times.
5. Participate in the development, implementation and updating of the Statewide CRS Provider Network Plan as requested by CRSA to ensure that pediatric specialty care is provided in the most effective manner to all CRS members throughout the state.

All material changes in the CRS provider network must be approved in advance by CRSA. A material change is defined as any change in overall business practice that could have an impact on 5% or more of the recipients, providers, or AHCCCS programs, or may significantly impact the delivery of services provided by the CRS Regional Contractor. CRSA must be notified of planned material changes in the provider network before the change process has begun, for example, before issuing a 60-day termination notice to a provider.

The Regional Contractor shall notify CRSA in writing within one (1) business day of any unexpected changes to its provider network. This notification shall include:

- 1. Information about how the change will affect the delivery of covered services;
- 2. The Regional Contractor plans for maintaining the quality of recipient care if the provider network change is likely to result in deficient delivery of covered services; and
- 3. The Regional Contractorsø plan to address and resolve any network deficiencies.

CRS Regional Contractors must notify providers and recipients in writing thirty (30) calendar days prior to the effective date of a program change or any other change in the network, excluding a provider leaving the network. The notification letter must be submitted to CRSA forty-five (45) calendar days prior to the effective date of the change for review and approval [42 CFR 438.10(f)(4)].

Within thirty (30) days of the CRS Regional Contractor communicating a change to the CRS network and/or members, CRS Regional Contractors must provide CRSA with evidence of how the communication with the CRS network and/or members was completed, such as provider/member newsletters, postings on the website, etc.

## **80.700 Request for Extension of Submission Deadline and Sanctions**

### **80.701 Request for Extension of Submission Deadline**

The CRS Regional Contractor shall request approval for an extension for report submission. The requirement to request approval for an extension applies to all reports due to CRSA (financial reporting and quality assurance reporting).

As soon as a CRS Regional Contractor is aware that they will not be able to submit a report by the required due date (but at least 10 working days prior to the due date) the CRS Regional Contractor must request in writing an approval for an extension. For due dates of reports please refer to your contract (Appendix G-1). The written request for extension for report submission should include the circumstances requiring the extension request and the requested timeframe for the extension.

### **80.702 Sanctions**

CRSA may impose financial sanctions on contractors for failure to perform as required, failure to submit timely and accurate reports, engaging in actions that jeopardize Federal Financial Participation, AHCCCS imposed sanctions on CRSA for action by the CRS Regional Contractors (e.g., pended encounter sanctions), or any other breach of the terms of this contract. Other sanctions may be imposed against the contractors and their service providers in accordance with defined CRSA policies.

Sanctions may be imposed for, but not limited to, the following actions:

1. Substantial failure to provide medically necessary services that CRSA is required to provide under the terms of this contract;
2. Imposition of premiums or charges in excess of the amount allowed under the AHCCCS 1115 Waiver;
3. Discrimination among CRS recipients on the basis of their health status of need for health care services;
4. Misrepresentation or falsification of information furnished to CMS or AHCCCSA or CRS;
5. Misrepresentation or falsification of information furnished to a recipient, potential recipient, or provider;
6. Failure to meet AHCCCS Financial Viability Standards;
7. Material deficiencies in CRS provider network;
8. Failure to meet quality of care and quality management requirements;
9. Failure to meet AHCCCS/CRS encounter standards;
10. Violation of other applicable State or Federal laws or regulations;
11. Failure to require subcontractors to increase the Performance Bond in a timely manner;
12. Failure to comply with any provisions contained in the contract;

13. Failure to report third party liability cases; or
14. Failure to meet contractual reporting requirements.

CRSA may impose the following types of sanctions:

1. Civil monetary penalties;
2. Appointment of temporary management for CRS Regional Contractors as provided in 42 CFR 438.706 and A.R.S. §36-2903 (M);
3. Suspension of payment for recipients after the effective date of the sanction until CRSA is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur; or
4. Additional sanctions allowed under statute or regulation that address areas of noncompliance.

The financial sanction process applies to all required reports that have not been granted an extension. For due dates of reports please refer to your contract (Appendix G-1). Required reports submitted must be substantially complete and correct.

If the report is not submitted within the thirty (30) day grace period, a sanction of \$500 per day will be levied until the report is received.

A second offence of an untimely submitted report of the same nature will not receive the thirty (30) day grace period. Sanctions will begin the day following the due date.

## **80.800 Corporate Compliance Program**

1. Each Regional Contractor shall have a Corporate Compliance Program, supported by a written plan. The plan shall include all seven elements required in 42 CFR 438.608. The seven elements are:
  - A. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards;
  - B. The designation of a compliance officer and a compliance committee that are accountable to senior management;
  - C. Effective training and education for the compliance officer and an organization's employees;
  - D. Effective lines of communication between the compliance officer and the organization's employees;
  - E. Enforcement of standards through well-publicized disciplinary guidelines;
  - F. Provision for internal monitoring and auditing;

- G. Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the CRSA contract.

The plan should also contain:

- A. Standards of conduct, procedures, internal controls, and system edits for the prevention and detection of fraud and abuse and compliance with federal and state requirements for the following areas of responsibility:
    - 1) Claims processing;
    - 2) Prior authorization, concurrent review and other utilization management activities;
    - 3) Quality management;
    - 4) Clinic services;
    - 5) Medical eligibility determinations;
    - 6) Financial category determinations;
    - 7) Encounter submissions;
    - 8) Financial reporting;
    - 9) Provider credentialing;
    - 10) Subcontracted services; and
    - 11) Provision for internal monitoring and auditing.
  - B. Provision for ensuring the reporting of suspected fraud or abuse within ten (10) days of discovery directly to:
    - 1) AHCCCSA (Office of Program Integrity) for situations involving Title XIX/Title XXI members, providers and/or funding using the AHCCCS Referral for Preliminary Investigation found on the AHCCCSA web site, with a copy to the CRSA Compliance Officer and
    - 2) The ADHS Compliance Officer for State only issues using the form on the ADHS web site.
  - C. Provision for ensuring compliance with 42 CFR § 438.610 related to prohibited affiliations with individuals debarred by Federal agencies.
  - D. Provision for ensuring compliance with Public Law 109-171, Section 1902(a) of the Social Security Act, 42, U.S.C., § 1396a related to employee education about false claims recovery.
2. Each Regional Contractor shall have a CRS Compliance Officer who reports directly to the CRS Regional Administrator and/or to the parent organization's Corporate Compliance Officer and whose responsibilities include:
- A. Overseeing, monitoring, and serving as the focal point for the CRS compliance program with the authority to review all documents and

- functions as they relate to fraud and abuse prevention, detection, and reporting,
- B. Maintaining a tracking log, with elements as specified by ADHS Compliance Officer, of all potential fraud and abuse issues for tracking and trending;
  - C. Having authority to independently refer potential member and provider fraud and abuse cases to AHCCCS-OPI and ADHS Compliance Officer;
  - D. Having direct access to senior management and legal counsel;
  - E. Providing training for employees, members, and providers which addresses fraud and program abuse prevention, recognition, and reporting and encourages them to report fraud and abuse without fear of retaliation:
    - 1) Sign-in sheets must be maintained for all training sessions; and
    - 2) Fraud and abuse training shall be incorporated into new employee orientation.
  - F. Attending quarterly ADHS Compliance Officer workgroup meetings held for the purpose of:
    - 1) Discussing compliance issues arising during the previous quarter;
    - 2) Examining new/emerging fraud and program abuse related subjects;
    - 3) Discussing and developing methods for use within the CRS Program to detect and reduce specific types of fraud and program abuse; and
    - 4) Receiving fraud and program abuse related training.
  - G. Establishing and maintaining a fraud and program abuse hotline. The hotline should allow for anonymous tips and information and should be assessable 24-hours a day, seven days a week (24/7 access does not mean live staffing ó electronic messages and e-mail would be adequate).
  - H. Attending fraud and abuse training provided by ADHS.

## **80.900 Business Continuity and Recovery Plan**

- 1. By October 1<sup>st</sup> of each year, staff from each CRS Regional contractor shall submit their Business Continuity and Recovery Plans to CRSA.
- 2. The CRS Regional Contractors shall include in their Business Continuity and Recovery Plans planning and training for all the elements as defined and listed in the Business Continuity and Recovery Plan policy (Policy 104 of the AHCCCS Contractor Operations Manual) including:
  - A. Electronic/telephonic failure at the CRS facility;

- B. Loss of primary computer system/records or networks;
  - C. Complete loss of use of the main site and any satellite sites;
  - D. Healthcare/CRS facility closure/Loss of a major CRS provider;
  - E. Arranging for medically necessary covered services for CRS members should the CRS facility become temporarily insufficient;
  - F. Communication with CRSA in the event of a business disruption;
  - G. Communication with key customers related to a business disruption;
  - H. Staff training on the Business Continuity and Recovery Plan; and
  - I. Periodic testing of the Business Continuity and Recovery Plan, at least annually.
3. The CRS Regional Contractors shall include their Business Continuity and Recovery Plan Required documentation of the following critical processes:
- A. Eligibility and Enrollment;
  - B. Scheduling;
  - C. Clinic Visits;
  - D. Prior-Authorization;
  - E. Surgeries;
  - F. Utilization Review/Concurrent Review;
  - G. Claims/Provider Payments; and
  - H. Grievance/Appeals and Quality of Care Concerns.
4. CRS regional contractors are required to notify CRSA of business continuity disruptions. Notification should include the following:
- A. Description of the disruption;
  - B. Plans for dealing with the disruption (for example, how you will reschedule clinic visits/surgeries);
  - C. Notification timeline: within 24 hours or next business day if on a weekend;
  - D. Form of notification: telephone followed in writing via letter to the Division Chief for Compliance at CRSA, (602) 542-1860, 150 N. 18<sup>th</sup> Avenue Suite #330; Phoenix, AZ 85007-3243; and
  - E. Some examples of disruption notification: loss of major provider; floods, loss of air conditioning, phone or computer system down time of greater than two days.
5. CRS Regional contractors will maintain and submit to CRSA education tracking forms and sign-in sheets for Business Continuity and Recovery Plan training provided.
6. By October 1<sup>st</sup> of each year the CRS Regional Contractors shall submit to CRSA the plan for testing their Business Continuity and Recovery Plan detailing timeline for testing and what will be tested. Documentation of the testing performed by the CRS Regional Contractors shall be submitted to CRSA annually upon completion.

## **80.1000 CRS Contractor Employee Training Requirements**

CRS Contractor employees must participate in appropriate training and educational opportunities within ninety (90) days of their start date in order to effectively meet the requirements of the ADHS/CRSA service delivery system. ADHS/CRSA requires that CRS Contractor staff and providers receive specific training with the intended purpose of meeting the following goals:

1. To promote a consistent family-centered practice philosophy;
2. To assist CRS Contractors in developing a qualified, knowledgeable, and culturally competent workforce; and
3. To ensure that services are delivered with the family-centered philosophy that reflects the vision and mission of the CRS Program.

### **80.1001 General Orientation and Annual Training Requirements**

1. At a minimum, the additional following content areas should be covered in CRS Contractor's new employee orientation:
  - a. CRS Program Overview;
  - b. Grievances and Appeals processes;
  - c. Quality of Care process;
  - d. Notice of Action;
  - e. Transition Planning;
  - f. Member Rights; and
  - g. Coordination of Care.
2. At a minimum, the following content areas must be covered in new employee orientation and annually thereafter:
  - a. Cultural Competency, which should include:
    - i. Culturally and Linguistically Appropriate Services (CLAS) Standards;
    - ii. Cultural Competency terms;
    - iii. Principles of family-centered care;
    - iv. Use of interpretation and language assistance services;
    - v. Limited English Proficiency (LEP);
    - vi. TDD/TTY and other Americans with Disabilities Act (ADA) accommodations;
    - vii. Grievances and provisions of culturally appropriate care; and
    - viii. Creating awareness concerning children and their families health related benefits, attitudes, values, and behaviors and incorporating them into practice.
  - b. Corporate Compliance (Fraud and Program Abuse), which should cover content area detailed in Section 80.800; and
  - c. Business Continuity and Recovery Plan.

**80.1002 Required Training Specific to Provider Service Representatives**

The following content areas must also be included in the orientation and training program for provider service representatives or any personnel responsible for providing policy and procedure clarifications and assistance to providers:

1. Claims processing;
2. Prior-authorizations; and
3. Claim disputes process.

**80.1003 CRSA's Learning Management System (LMS)**

ADHS/CRSA provides many trainings through the LMS, an e-learning environment. To participate in trainings via LMS, participants must first register to receive access to LMS by contacting the E-Learning Program Manager at CRSA at (602) 542-1860.

**80.1004 CRSA Training Catalog and Training Requests**

ADHS/CRSA will maintain a catalog of trainings available to contractor staff and their providers. The trainings will be available through the Learning Management System (LMS), face to face, and/or video conference. The training catalog is available on the ADHS/CRSA web page. Trainings included in the catalog are:

1. Cultural Competency;
2. Fraud and program abuse;
3. Grievance and Appeals processes;
4. Quality of Care process;
5. Notice of Action;
6. Business Continuity and Recovery Plan;
7. Transition Planning;
8. Member Rights, and
9. Coordination of Care.

CRSA will assess the need for other training topics on an on-going basis.

**Attachment 1**

***Quality of care acknowledgment letter (On Regional Contractor letterhead)***

**If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.**

**Si usted tiene dificultades leyendo este aviso porque las letras son demasiado pequeñas o las palabras son muy difícil para leer, favor de llamarnos al xxxxxx y alguien le asistirá.**

**XXX-XXX-XXXX or (800) XXX-XXXX**

Date

*(Name of person filing the grievance)*

Address

City, State, Zip

RE: *(CRS Member # & AHCCCS # if applicable)*

Dear *(Name)*:

(Phoenix, Tucson, Flagstaff, Yuma) Children's Rehabilitation Services at the (Phoenix, Tucson, Flagstaff, Yuma address), has received your concerns related to care you have been requesting for your son/daughter through CRS.

(Phoenix, Tucson, Flagstaff, Yuma) CRS clinic will research and respond to this issue. Be assured this issue will be given full consideration. A written response will be sent when the research into this issue has been completed.

This information will be kept confidential under 42 CFR 434.34, ARS 8-546.11(C)(11), ARS 36-2401, et seq., ARS 36-445, and ARS 41-1959C(5).

Thank you for contacting CRS regarding this issue. The quality of health care of all of our members is important to us. You can contact XXXXXXXXXX, Quality Management Manager at (XXX) XXX-XXXX if you have any questions regarding this issue.

Sincerely,

*Name and credentials*XXXXXXXXXX

*Title*

**Attachment 2**

*Quality of care resolution letter (On Regional Contractor  
letterhead)*

**If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.**

**Si usted tiene dificultades leyendo este aviso porque las letras son demasiado pequeñas o las palabras son muy difícil para leer, favor de llamarnos al xxxxxx y alguien le asistirá.**

XXX-XXX-XXXX or (800) XXX-XXXX

Date

*(Name of person filing the grievance  
Address  
City, State, Zip)*

RE: *(CRS Member # & AHCCCS # if applicable)*

Dear *(Name)*:

(Phoenix, Tucson, Flagstaff, Yuma) Children's Rehabilitation Services has completed its review related to XXXXXXXXXXXXXXXXXXXX.

*Provide explanation in lay person's terms*

This information will be kept confidential under 42 CFR 434.34, ARS 8-546.11(C)(11), ARS 36-2401, et seq., ARS 36-445, and ARS 41-1959C(5).

Thank you for contacting CRS regarding this issue. The quality of health care of all of our members is important to us. You can contact XXXXXX, at (XXX) XXX-XXXX if you have any questions regarding this issue.

Sincerely,

*Name and credentials  
Title*

## Attachment 3

### QUALITY OF CARE CONCERN SEVERITY LEVELS

#### Level 0- Track only:

*No risk for it to be a quality of care concern, risk of harm, permanent damage, increased cost of care, lengthened stay, permanent damage, or potential media event. Concerns may be related to physical elements of the clinic and discourtesy.*

#### Level 1- Concern that MAY impact the member if not resolved:

*Potential unsafe home environment; non-compliance with appointment scheduling or wait time requirements; need for information or referral to resolve an issue.*

#### Level 2- Concern that WILL impact the member if not resolved:

*Including slow, or no responsiveness to a request for evaluation, treatment other request; member rights violation; inadequate case management; physician clinic cancellations; availability/timeliness of transportation for medical appointments.*

#### Level 3- Concern that IMMEDIATELY impacts the member and is considered life threatening or dangerous

*Including situations of immediate jeopardy to the member; abuse and neglect; inadequate or inappropriate care of an acute condition; denial of services deemed medically necessary by the member/provider; potential provider misconduct; issues with, or the potential for, adverse media coverage or the potential for a lawsuit; and issues referred by the AHCCCS Director's Office.*

#### Level 4- Concern that no longer impacts the member but may have potential to be life threatening or dangerous to other members:

*Unexpected death has resulted, directly or indirectly as a result of care given or omitted. Media coverage assured. Lawsuit filed or in process.*

*Examples include cases abuse and neglect; unexpected deaths; and cases from the Governor's Office, Legislature, or ADHS Director/Assistant Director's Office regardless of the nature.*

## Attachment 4

### Quality of Care Categories

MAIN CATEGORY	SUB-CATEGORY
Availability, Accessibility & Adequacy (AAA)	Specialty selection
Availability, Accessibility & Adequacy (AAA)	Specialty change
Availability, Accessibility & Adequacy (AAA)	Access to services
Availability, Accessibility & Adequacy (AAA)	Access to specialists
Availability, Accessibility & Adequacy (AAA)	Adequacy of provider network
Availability, Accessibility & Adequacy (AAA)	Appointment availability
Availability, Accessibility & Adequacy (AAA)	Delay in referral
Availability, Accessibility & Adequacy (AAA)	Delay in treatment/service
Availability, Accessibility & Adequacy (AAA)	Provider refusal to provide care
Availability, Accessibility & Adequacy (AAA)	Telephone access
Availability, Accessibility & Adequacy (AAA)	Transportation
Availability, Accessibility & Adequacy (AAA)	DME
Availability, Accessibility & Adequacy (AAA)	Enviromental Modifications
Availability, Accessibility & Adequacy (AAA)	Other
Effectiveness/Appropriateness of Care	Inappropriate treatment
Effectiveness/Appropriateness of Care	Treatment is ineffective or below medical standards
Effectiveness/Appropriateness of Care	Non-formulary medications
Effectiveness/Appropriateness of Care	Missed diagnosis
Effectiveness/Appropriateness of Care	Dietary services inappropriate
Effectiveness/Appropriateness of Care	Skin integrity
Effectiveness/Appropriateness of Care	Access to medical care
Effectiveness/Appropriateness of Care	Delay in providing medical records or treatment plan to PCP
Effectiveness/Appropriateness of Care	Inappropriate transfer
Effectiveness/Appropriateness of Care	Inappropriate discharge
Effectiveness/Appropriateness of Care	Other
Safety/Risk Management	Pharmacy Prescription error
Safety/Risk Management	Injury/accident
Safety/Risk Management	Unsafe enviroment
Safety/Risk Management	Poor operation or conditions (DME)
Safety/Risk Management	Documentation/medical record
Safety/Risk Management	Altered medical records
Safety/Risk Management	Discharge AMA
Safety/Risk Management	Receipt of services AMA
Safety/Risk Management	Unexpected death
Safety/Risk Management	Other

**Children's Rehabilitative Services**

Member Rights/Respect and Caring	Continuity of caring
Member Rights/Respect and Caring	Coordination of care
Member Rights/Respect and Caring	Advance directives
Member Rights/Respect and Caring	Disrespectful/unprofessional conduct by provider
Member Rights/Respect and Caring	Disrespectful/inappropriate conduct by member
Member Rights/Respect and Caring	Not including member/parent in plan of care
Member Rights/Respect and Caring	Member dissatisfaction with treatment plan or care provided
Member Rights/Respect and Caring	Physical abuse
Member Rights/Respect and Caring	Physical neglect
Member Rights/Respect and Caring	Emotional abuse
Member Rights/Respect and Caring	Culturally insensitive
Member Rights/Respect and Caring	Restraints-physical
Member Rights/Respect and Caring	Restraints-chemical
Member Rights/Respect and Caring	Denial letter(s) not provided
Member Rights/Respect and Caring	Reduction in service letter(s) not provided
Member Rights/Respect and Caring	No access to medical records
Member Rights/Respect and Caring	No grievance process information provided
Member Rights/Respect and Caring	Other
Denial, Decrease or Discontinuance of Covered	Denial of services- not medically necessary
Denial, Decrease or Discontinuance of Covered	Denial of services- no prior authorization
Denial, Decrease or Discontinuance of Covered	Denial of services-not a covered service
Denial, Decrease or Discontinuance of Covered	Denial of services-eligibility
Denial, Decrease or Discontinuance of Covered	Denial of services payer of last resort
Denial, Decrease or Discontinuance of Covered	Decrease in the amount of service previously provided
Denial, Decrease or Discontinuance of Covered	Discontinuance of service provided
Denial, Decrease or Discontinuance of Covered	Discontinuance of previously covered benefit
Denial, Decrease or Discontinuance of Covered	Other
Fraud (i.e., by a member, a provider, or financial)	Referrals to entities in which the provider or family member has a financial interest
Fraud (i.e., by a member, a provider, or financial)	Inappropriate billing
Fraud (i.e., by a member, a provider, or financial)	Inappropriate use of covered benefit
Fraud (i.e., by a member, a provider, or financial)	Use of service by someone other than an enrolled member
Fraud (i.e., by a member, a provider, or financial)	Altered medical record due to fraudulent action

## Attachment 5

*(Regional Contractor Letterhead)*

**If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at (code)-phone # and someone will assist you.**

### NOTICE OF ACTION

Date

To: Name  
Address  
City, State Zip

From:

You have asked that INSERT: Name of the Contractor approve: INSERT: Describe services requested on behalf of the member in easily understood terms. We have reviewed your request and decided that: INSERT: Describe action taken (or intended to be taken) by Contractor, including the relevant dates, in member specific terms and in easily understood language.

Our decision is based on the following reasons: INSERT: The explanation of the Contractor's decision must be complete and in commonly understood language. It must specify the relevant laws, rules, policies, etc. for the action. The explanation must also be both member and fact specific, describing the member's condition and the reasons supporting the Contractor decision. Generic statements are not adequate. Any decisions to deny or reduce a service authorization request must be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.

You can ask us to look at our decision again. This is called an appeal. You can have someone help you appeal. Also, your doctor or other health care provider can appeal for you if you write telling us so. If you appeal you must contact us by **INSERT DATE: no later than 60 days after the date of this Notice.** *You can write or call us to appeal.* If you write your appeal, it must be received by **INSERT DATE: 60 days from the date of the Notice.**

Before we make our decision, you can give us any information that you think will be helpful. You can ask to set up a meeting so that you can give us the information in person, or you can give it to us in writing. You can also see your case file, including medical records and other information about your appeal, before you give us information and before we decide the appeal. After we review your appeal, we will send you our decision in writing. This decision is called the Notice of

## Appeal Resolution.

We will make a decision within 30 days. However, you may ask for a faster review of your appeal. This is called an "expedited appeal." You can ask for a faster review if your/your child's life or health could be in danger or your/their ability to attain, maintain or regain maximum function would be damaged by waiting the normal 30 days for a decision on your appeal. If your health care provider tells us this, the appeal will be decided in 3 working days. You may also ask us to decide the appeal in 3 working days. If you ask us yourself and we agree, we will make a decision in 3 working days. If you ask for a faster review (expedited appeal), tell us how your health will suffer if we take 30 days to decide your appeal. If we do not agree that a faster review is needed, we will write you within 2 days, and we will also try to call you. Then we will decide your appeal within 30 days.

For all appeals, up to 14 more days may be taken to make a decision on your case. This is called an extension. If we want an extension we will tell you why it is needed. If you want an extension, you can you can ask for it by writing or calling us.

## **TO REQUEST CONTINUED BENEFITS DURING THE INSERT: Name of Contractor APPEALS PROCESS**

You can ask that the services listed in this letter continue while we make a decision. If you want those services to continue, you must say so when you appeal. This applies if we are stopping or reducing an approved service ordered by your doctor or other health care provider that you are receiving now. This also applies to a service we have denied if the doctor or other health care provider says that the service is a necessary continuation of a service that was approved before. Your service will only be continued if you appeal by **INSERT DATE: (the later of: 10 days from the date of the Notice OR the intended date of the action)**. If you do not win your appeal, you will be responsible for paying for these services provided during the appeal.

If you have any questions about filing an appeal or if you need help, you can call us at **INSERT: phone number.** Please send your written appeal to: **INSERT: address.**

Sincerely,

**INSERT: Signature of Medical Director**

**INSERT: Name of Medical Director**

cc. AHCCCS Plan  
PCP/provider  
CRSA  
Chart copy

## Attachment 5

*(Usar Papel de Membrete del Contratista Regional de CRS)*

Si usted tiene dificultades leyendo este aviso porque las -letras son demasiado pequeñas o las palabras son muy difícil para leer, favor de llamarnos y alguien le asistirá.

*(Code)-Phone # or (800) --- ---*

<http://www.ahcccs.state.az.us/Regulations/OSPPolicy/default.asp>

### Aviso de Acción

Fecha

A:      Nombre  
         Dirección  
         Ciudad, Estado, Código Postal

De:

Usted ha pedido que **PONER:** Nombre del Contratista apruebe: **PONER:** En términos fáciles de entender, describa los servicios que fueron solicitados a nombre del miembro. Se ha revisado su petición y se decidió esto: **PONER:** Describa la acción tomada ( o que intenta ser tomada) por el Contratista, incluyendo las fechas relevantes, en términos específicos para el miembro y en un lenguaje fácil de comprender.

Nuestra decisión esta basada en las siguientes razones: **PONER:** La explicación de la decisión del Contratista debe ser completa y en un lenguaje comúnmente entendible. Debe especificar las leyes relevantes, las reglas, las pólizas, etc. para la acción. Esta explicación debe especificar los hechos y también ser concreta para el miembro, describiendo la condición del miembro y las razones apoyando la decisión tomada por el Contratista. Las declaraciones genéricas no son adecuadas. Cualquier decisión de negar o reducir una solicitud para la autorización del servicio debe ser hecha por un profesional del cuidado de la salud que tiene pericia clínica apropiada para tratar la condición o enfermedad del miembro.

Usted puede pedir que la decisión sea revisada nuevamente. Esto se llama una apelación. Usted puede obtener ayuda de otra persona con su apelación. También, su doctor u otro proveedor de cuidado de salud pueden hacer una apelación por parte suya, si usted nos deja saber por escrito que eso va pasar. Si usted decide hacer una apelación tiene que avisarnos en **PONER FECHA:** a no más tardar 60 días después de la fecha de este Aviso. Usted puede hacer su apelación enviándonos una carta o hablándonos por teléfono. Si usted decide escribir su apelación, debe de ser recibida para **PONER FECHA:** 60 días desde de la fecha de este Aviso.

Antes de que se tome una decisión usted puede dar cualquier información que crea que sea beneficiosa. Usted puede pedir que se haga una reunión, para darnos la información en persona, o puede enviar la información por escrito. Antes de tomar una decisión sobre su apelación, y antes de darnos información adicional, usted tiene el derecho de revisar su archivo, incluyendo los expedientes médicos y otra información sobre su apelación. Después de revisar su apelación, se le enviará la decisión por escrito. Esta decisión se llama Aviso de la Resolución de la Apelación.

Tomaremos una decisión en un plazo de 30 días. Sin embargo, usted puede pedir una revisión más rápida para su apelación. Esto se llama *Apelación Acelerada*.

Usted puede solicitar una revisión mas rápida si su salud o su vida/o la de su hijo(a) estuviera en peligro o si la capacidad de usted/ellos de lograr, mantener o la recuperación de la función normal se deteriorara, por esperar los 30 días que normalmente se puede tomar para hacer una determinación por su apelación. Si su proveedor de cuidado de salud nos informa que esto puede suceder, la apelación será decidida dentro de 3 días laborales. Usted también tiene el derecho de pedirnos que tomemos una determinación sobre su apelación dentro de 3 días laborales. Si usted mismo nos pide tomar una decisión más rápida y si estamos de acuerdo, tomaremos una decisión en 3 días laborales. Si usted pide una revisión más rápida (apelación acelerada), explíquenos como sufrirá su estado de salud, si nos tardamos los 30 días para hacer una decisión para su apelación. Si no estamos de acuerdo que se necesita hacer una revisión rápida, le avisaremos por medio escrito dentro de 2 días, y también trataremos de hablarle por teléfono. Luego decidiremos dentro de los 30 días sobre su apelación.

Para todas las apelaciones, 14 días más pueden ser tomados para hacer una decisión sobre su caso. Esto se llama una extensión. Si queremos una extensión le explicaremos por qué es necesario. Si usted quiere una extensión, puede pedirlo, llamándonos por teléfono o escribiéndonos.

#### **PARA SOLICITAR QUE SUS BENEFICIOS CONTINUEN DURANTE EL PROCESO DE APELACIÓN DE PONER: Nombre de Contratista**

Usted puede pedir que los servicios mencionados en esta carta continúen mientras llegamos a una decisión. Si usted quiere que los servicios continúen, debe decirlo cuando haga su apelación. Esto se aplica cuando reducimos o terminamos los servicios aprobados y ordenados por su doctor u otro proveedor de salud que usted esta recibiendo en este momento. También esto se aplica para los servicios que le hemos negado, si su doctor u otro proveedor de salud dice que el servicio necesitado es una continuación de un servicio que fue aprobado antes. Su servicio será continuado solamente, si usted solicita una apelación en **PONER FECHA: (No mas tardar: 10 días a partir de la fecha del aviso ó de la fecha prevista de la acción)**. Si usted no gana su apelación, usted será responsable en pagar los servicios proveídos durante su apelación.

Si usted necesita ayuda o tiene preguntas sobre como solicitar una apelación, nos puede llamar al **PONER: numero de teléfono**. Envíe por favor su apelación escrita al: **PONER: dirección**.

Respetuosamente,

**PONER:** Firma del Director Médico

**PONER:** Nombre del Director Médico

- dd. Plan de AHCCCS  
Doctor/proveedor  
CRSA  
Copia de archivo (not the translation of chart copy, instead it states copy of archives)

**Attachment 6**

*(On Regional Contractor letterhead)*

**If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.**

**XXX-XXX-XXXX or (800) XXX-XXXX**

**Notification of Extension for Service Authorization Timeframe**

Date

*Name of Member/Guardian*

*Address*

*City, State, Zip)*

RE: *(CRS Member Name, Member # & AHCCCS #)*

Dear *(Name)*:

We are requiring an extension in the review and approval/denial of your requested *(identify the service)*. It may take up to fourteen extra days for the processing of your requested service. In no case will this process take more than 28 days from the date we received the request from your provider. Please call if you have any questions, at XXX-XXX-XXXX, and we will be happy to help you with the call.

On behalf of *(Phoenix, Tucson, Flagstaff, Yuma)* CRS, thank you for your patience and understanding.

If you disagree with our extension of the timeframes, you can make a grievance. You may contact us at INSERT CONTACT NUMBER FOR ORAL GRIEVANCES or you can send a written grievance to INSERT ADDRESS.

If you need help with making a complaint [insert local advocacy organizations] For more information about this notice, you may contact the person whose name and address appears at the top of this notice. You may also refer to your member handbook for more information about the service authorization process.

Sincerely,

XXXXXXXXXXXX

*Name and credentials*

*Title*

Cc:

Requesting Provider

ALTCS/Acute Care Provider

**Attachment 6**

*(Usar Papel de Membrete del Contratista Regional de CRS)*

**Si usted tiene dificultades leyendo este aviso porque las letras son demasiado pequeñas o las palabras son muy difíciles de leer, favor de llamarnos al xxxxxx y alguien le asistirá.**

XXX-XXX-XXXX or (800) XXX-XXXX

**Notificación de la Extensión del Horario  
Para Autorizaciones De Servicios**

Fecha

*Nombre de Miembro/Guardián*

*Dirección*

*Ciudad, Estado, Código Postal*

De: *(Nombre de Miembro, # miembro de CRS e # identificación de AHCCCS)*

Estimado *(Nombre)*:

Estamos requiriendo una extensión en la revisión y la aprobación/negación en su solicitud (identifique el servicio). Puede tomar hasta catorce días adicionales para procesar el servicio solicitado. En ningún caso éste proceso tomará más de 28 días a partir de la fecha que recibimos la petición de su proveedor. Por favor llame si usted tiene cualquier pregunta, al XXX-XXX-XXXX, y estaremos complacidos de ayudarle con su llamada.

Por parte de *(Phoenix, Tucson, Flagstaff, Yuma)* CRS, gracias por su paciencia y comprensión.

Si usted no está de acuerdo con el horario de nuestra extensión, usted puede presentar una queja. Usted puede comunicarse con nosotros al PONER NUMERO DE CONTACTO PARA QUEJAS ORALES o usted puede enviar su queja escrita en PONER DIRECCION.

Si usted necesita ayuda para presentar una queja, [inserte organizaciones de ayuda local o legal.]

Para más información sobre este aviso, usted puede comunicarse con la persona de quién el nombre y dirección aparece en la parte superior de este aviso. Usted también se puede referir al manual de los miembros para más información sobre el proceso de la autorización de servicios.

Sinceramente,

XXXXXXXXXXXXX

*Nombre y credenciales*

*Titulo*

Cc:

Proveedor solicitante

**Attachment 7**

*(CRS Regional Contractor Letterhead)*

**Notice to ALTCS/Acute Care Contractor of Non-Coverage by Children's  
Rehabilitative Services**

To (ALTCS/Acute Care Contractor)

Date:

Re: *(Member name, CRS #, AHCCCS #)*

A CRS provider or member has asked that *(name of CRS clinic)* approve: *(describe services including date requested)*

The *(name region)* CRS Regional Medical Director has reviewed and denied the requested service as not covered by CRS.

This decision is based on the following: *(Any decisions to deny or reduce a service must be made by a physician, who has appropriate clinical expertise in treating the member's condition or disease. The explanation must be complete and specify the relevant laws, rules, policies etc. for the action. The explanation must also be both member and fact specific, describing the member's condition and the reasons supporting the denial.)*

If you disagree with this decision, you have the right to appeal the decision and file a Request for Review in writing with the CRS Regional Medical Director no later than 10 business days after receipt of this notice.

Sincerely,

---

Medical Director

Cc: Requesting Physician/Provider  
File copy  
CRSA

**Attachment 7**

*(Usar Papel de Membrete del Contratista Regional de CRS)*

**Aviso al Contratista del Programa de ALTCS/Acute Care  
No Proporcionar Cobertura de Servicios por parte de CRS**

A: Nombre del Contratista

Fecha:

Acerca de: (Nombre del miembro, # miembro de CRS e # identificación de AHCCCS)

Un proveedor de CRS o un miembro de CRS ha pedido que *(nombre de la clínica de CRS)* apruebe: *(describa los servicios solicitados, incluyendo la fecha que fueron solicitados).*

El Director Regional Médico de CRS *(nombre de la región)* ha revisado y negado el servicio solicitado por que no es un servicio que esta cubierto por CRS.

Esta decisión se basa en lo siguiente: *(Cualquier decisión para negar o para reducir un servicio debe ser hecha por un médico, el cual tiene pericia clínica apropiada en tratar la condición o la enfermedad del paciente o miembro. La explicación debe ser completa y especificar las leyes relevantes, las reglas y las pólizas, etc. para la acción tomada. Esta explicación debe especificar los hechos y también ser concretamente para el miembro, describiendo la condición del mismo y las razones que apoyen la negación de este servicio.)*

Si usted no esta de acuerdo con esta decisión, tiene el derecho de apelar la decisión y someter por escrito una Solicitud para Revisión al Director Regional Médico de CRS, a no mas tardar 10 días laborales después de recibir esta carta.

Sinceramente,

---

Director Médico

C.C: Solicitud enviada por parte del Doctor/Proveedor

Copia de Archivo  
CRSA

**Attachment 8**

*(CRS Regional Contractor Letterhead)*

**Notice of Decision by CRS  
on  
ALTCS/Acute Care Contractor Request for Review**

**Date**

**To: ALTCS/Acute Care Contractor Name  
Address**

Re: *(Member name, CRS Member # and AHCCCS ID#)*

Dear: *(Plan Medical Director)*

We received your Request for Review dated \_\_\_\_\_ asking us to review our decision to \_\_\_\_\_.

After reviewing our original decision, we have decided *(that the first decision was right/ **or**/ to change our decision to \_\_\_\_\_.)* We have made this decision based on *(Please include the legal citations or authorities supporting the determination.)*

If you do not agree with our decision you may file a request for a hearing with the AHCCCS Administration within 30 days of receipt of this letter.

If you have questions, please call us at *(XXX) XXX-XXXX*.

Sincerely,

\_\_\_\_\_  
CRS Regional Medical Director

**Attachment 8**

(Usar Papel de Membrete del Contratista Regional de CRS)

**Aviso de la Decisión por CRS  
sobre su  
Solicitud para una Revisión para el Plan de Salud AHCCCS/Contratista del  
Programa**

Fecha

A: Nombre del Plan de Salud  
Dirección

Re: *(Nombre del miembro, # miembro de CRS e # identificación de AHCCCS)*

Estimado: *(Director Médico del Plan)*

Hemos recibido su solicitud para una revisión, con fecha \_\_\_\_\_, pidiéndonos considerar nuestra decisión sobre \_\_\_\_\_.

Después de examinar la decisión original, se ha determinado *(que la primera decisión estaba correcta o/ cambiar nuestra decisión a \_\_\_\_\_.)* Se ha tomado ésta medida basado en lo siguiente *(Incluya por favor las citas legales o las autoridades que apoyen la determinación.)*

Si usted no esta de acuerdo con nuestra decisión, puede solicitar una audiencia con la Administración de AHCCCS dentro de los 30 días siguientes a que reciba esta carta.

Si usted tiene preguntas, favor de llamarnos al *(XXX) XXX-XXXX*.

Sinceramente,

\_\_\_\_\_  
Director Médico Regional de CRS

**Attachment 9**

**Notice to AHCCCS Health Plan/Program Contractor of Non-Coverage by  
Children's Rehabilitative Services**

To (AHCCCS Plan name)

Date:

Re: (Member Name, CRS #, AHCCCS #)

A CRS provider or member has asked that *(name of CRS clinic)* approve: *(describe services including date requested)*

The *(name region)* CRS Regional Medical Director has reviewed and denied the requested service as not covered by CRS.

This decision is based on the following: *(Any decisions to deny or reduce a service must be made by a physician, who has appropriate clinical expertise in treating the member's condition or disease. The explanation must be complete and specify the relevant laws, rules, policies etc. for the action. The explanation must also be both member and fact specific, describing the member's condition and the reasons supporting the denial.)*

If you disagree with this decision, you have the right to file a Request for Review in writing with the CRS Regional Medical Director no later than 10 business days after receipt of this notice.

Sincerely,

\_\_\_\_\_  
Medical Director

cc: Requesting Physician/Provider  
File copy  
CRSA

**Attachment 9**

*(Usar Papel de Membrete del Contratista Regional de CRS)*

**Aviso de la Decisión por CRS  
sobre su  
Solicitud para una Revisión para el Plan de Salud AHCCCS/Contratista del  
Programa**

Fecha

A: Nombre del Plan de Salud  
Dirección

Re: (Nombre del miembro, # miembro de CRS e # identificación de AHCCCS)

Un proveedor de CRS o un miembro de CRS ha pedido que *(nombre de la clínica de CRS)* apruebe: *(describa los servicios solicitados, incluyendo la fecha que fueron solicitados).*

El Director Regional Médico de CRS *(nombre de la región)* ha revisado y negado el servicio solicitado por que no es un servicio que esta cubierto por CRS.

Esta decisión se basa en lo siguiente: *(Cualquier decisión para negar o para reducir un servicio debe ser hecha por un médico, el cual tiene pericia clínica apropiada en tratar la condición o la enfermedad del paciente o miembro. La explicación debe ser completa y especificar las leyes relevantes, las reglas y las pólizas, etc. para la acción tomada. Esta explicación debe especificar los hechos y también ser concretamente para el miembro, describiendo la condición del mismo y las razones que apoyen la negación de este servicio.)*

Si usted no esta de acuerdo con esta decisión, tiene el derecho de apelar la decisión y someter por escrito una Solicitud para Revisión al Director Regional Médico de CRS, a no mas tardar 10 días laborales después de recibir esta carta.

Sinceramente,

---

Director Médico Regional de CRS

C.C: Solicitud enviada por parte del Doctor/Proveedor  
Copia de Archivo  
CRSA

**Attachment 10**

*(On Regional Contractor letterhead)*

**If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.**

**Notification of Extension for Referral to ALTCS/Acute Care Contractor**

Date

*Name of Member/Guardian*

*Address*

*City, State, Zip)*

RE: *(CRS Member Name, Member # & AHCCCS #)*

Dear *(Name)*:

We are forwarding your request for *(identify the service)* to your AHCCCS Plan. It may take up to fourteen extra days for your Plan to receive and process the request. In no case will this process take more than 28 days from the date we received the request from your provider. Please call your AHCCCS Plan if you have any questions, or, if you do not know who to contact at your AHCCCS Plan, please call us at XXX-XXX-XXXX, and we will be happy to help you with the call.

On behalf of *(Phoenix, Tucson, Flagstaff, Yuma)* CRS, thank you for your patience and understanding.

If you disagree with our extension of the timeframes, you can make a grievance. You may contact us at INSERT CONTACT NUMBER FOR ORAL GRIEVANCES or you can send a written grievance to INSERT ADDRESS.

If you need help with making a complaint [insert local advocacy organizations] For more information about this notice, you may contact the person whose name and address appears at the top of this notice. You may also refer to your member handbook for more information about the service authorization process.

Sincerely,

XXXXXXXXXXXX

*Name and credentials*  
*Title*

Cc:  
Requesting Provider  
ALTCS/Acute Care Contractor

**Attachment 10**

*(Usar Papel de Membrete del Contratista Regional de CRS)*

**Si usted tiene dificultades leyendo este aviso porque las letras son demasiado pequeñas o las palabras son muy difíciles de leer, favor de llamarnos al xxxxxx y alguien le asistirá.**

**XXX-XXX-XXXX or (800) XXX-XXXX**

**Notificación de la Extensión para la Remisión al ALTCS/Acute Care  
Contractor**

Fecha

*Nombre de Miembro/Guardián*

*Dirección*

*Ciudad, Estado, Código Postal*

De: *(Nombre de Miembro, # miembro de CRS e # identificación de AHCCCS)*

Estimado *(Nombre)*:

Hemos enviado su petición para *(identifique el servicio)* a su plan de AHCCCS. Puede tomar hasta catorce días adicionales para que su Plan reciba y procese la petición. En ningún caso este proceso tomara más de 28 días a partir de la fecha que recibimos la petición de su proveedor. Por favor llame a su plan de AHCCCS si tiene cualquier pregunta, o, si no sabe con quién comunicarse al plan de AHCCCS, por favor llame al XX-XXX-XXXX, y estaremos complacidos de ayudarle con su llamada.

Por parte de *(Phoenix, Tucson, Flagstaff, Yuma)* CRS, gracias por su paciencia y comprensión.

Si usted no está de acuerdo con el horario de nuestra extensión, usted puede presentar una queja. Usted puede comunicarse con nosotros al PONER NUMERO DE CONTACTO PARA QUEJAS ORAL o usted puede enviar su queja escrita a PONER DIRECCION.

Si usted necesita ayuda para presentar una queja, [inserte organizaciones de ayuda locales o legales.] Para más información sobre este aviso, usted puede comunicarse con la persona de quién el nombre y dirección aparece en la parte superior de este aviso. Usted también se puede referir al manual de los miembros para más información sobre el proceso de la autorización de

servicios.

Sinceramente,

XXXXXXXXXXXXX

*Nombre y credenciales*

*Titulo*

Cc:

Proveedor Solicitante

Contratista de ALTCS/Acute Care